My Kid's Doc

SOUTHFIELD

Third Party Consent for Treatment and Examination

Patient Name(s): _____ DOB:_____

_____ DOB:_____

_____ DOB:_____

I, _____, the parent/guardian of the above named child(ren) give permission for:

_____

to seek medical care and treatment for him/her/them.

I can be reached by phone _____

I can be reached by email _____

I can be reached by fax _____

My signature below certifies my consent for examination and treatment of my child(ren).

_____ _____

Signature of Parent and/or Guardian Date

_____ _____

Witness Signature Date

This consent is valid for one year from date of signature.